



Intimate partner violence and HIV: embracing complexity

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Intimate partner violence and HIV: embracing complexity

Dick Durevall and Annika Lindskog (January, 2015) explore the association between intimate partner violence (IPV) and HIV infection in Demographic and Health Survey (DHS) data.¹ We welcome Durevall and Lindskog's examination of the confluence of risk factors that might place women at risk of HIV infection, building from our earlier analysis of an overlapping set of DHS datasets,² and their careful interpretation of the results they find. However, we believe that Sunita Kishor's interpretation of their study,³ in relation to our earlier study on the same question,² necessitates some elaboration to ensure an accurate interpretation of this analysis.

Kishor praises Durevall and Lindskog's use of a "clean"³ control group of women who have experienced no forms of IPV or male controlling behaviour in making comparisons with women who have experienced each combination of the exposures under investigation. Although this approach is informative, it answers a question that is fundamentally different from those addressed in previous studies, including ours, comparing all women with each exposure to the remaining sample. Durevall and Lindskog are implicitly making the case that the multiple dimensions of IPV and male controlling behaviour are intertwined and acting jointly, and that analysing their impact individually is not meaningful. This situation might well be the case, but their approach does not allow the identification of which specific exposure (ie, violence or controlling behaviour) is driving any apparent association with HIV risk. We suggest that both the "clean" approach and previously employed specifications (such as our own) are valid and useful methods for risk assessment.

Kishor also offers a broad-stroke conclusion: that Durevall and

Lindskog's work confirms that "women who experience intimate partner violence have an increased risk of being HIV positive".³ In fact, their pooled analysis finds a significant association between IPV and HIV in three high HIV prevalence countries, but not elsewhere, for women experiencing both violence and male controlling behaviour. Rather than concluding that IPV and HIV are inextricably linked, we read Durevall and Lindskog's findings as highlighting an emerging theme in the literature: that non-negligible associations between IPV and HIV can be seen in high-prevalence settings for women in highly vulnerable situations who face many deprivations, including multiple forms of violence.^{4,5}

Notwithstanding the fact that controlling, coercive violence has many other negative effects that make it well worth tackling for its own sake, in the context of an HIV epidemic facing resource constraints it is crucial to understand where, when, and for whom such experiences are associated with HIV, and in what settings and in which ways this association can be nullified. Drivers are likely to be found at the individual, interpersonal, and institutional levels. As Kishor notes: "what is less understood is the 'why' behind these associations and the direction of causality".³ We agree that obtaining such knowledge will be crucial to effecting change.

We declare no competing interests.

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*Guy Harling, Alexander C Tsai, SV Subramanian
gharling@hsph.harvard.edu

Department of Global Health and Population (GH), and Department of Social and Behavioral Sciences (SVS), Harvard T H Chan School of Public Health, Huntington Avenue, Boston MA 02115, USA; and Center for Global Health, Massachusetts General Hospital, Boston, MA, USA (ACT)

1 Durevall D, Lindskog A. Intimate partner violence and HIV in ten sub-Saharan African countries: what do the Demographic and Health Surveys tell us? *Lancet Glob Health* 2015; **3**: e34–43.

2 Harling G, Msisha W, Subramanian SV. No association between HIV and intimate partner violence among women in 10 developing countries. *PLoS One* 2010; **5**: e14257.

3 Kishor S. Intimate partner violence and HIV: clearing up confusion. *Lancet Glob Health* 2015; **3**: e4–5.

4 Jewkes RK, Dunkle K, Nduna M, Shai N. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study. *Lancet* 2010; **376**: 41–48.

5 Kouyoumdjian FG, Calzavara LM, Bondy SJ, et al. Intimate partner violence is associated with incident HIV infection in women in Uganda. *AIDS* 2013; **27**: 1331–38.

